

**MARICOPA INTEGRATED HEALTH SYSTEM HEALTH PLANS
PROTOCOL**

SUBJECT: Electrical Nerve Stimulator (ENS)	Protocol #: PA P233.02 Protocol Pages: 1 Attachments: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Initial Effective Date: July 1999 Latest Review Date: May 2002
APPLIES TO: MHP <input checked="" type="checkbox"/> MLTCP <input checked="" type="checkbox"/> MSSP <input checked="" type="checkbox"/> HEALTHSELECT <input checked="" type="checkbox"/>	
MIHS HEALTH PLANS APPROVALS: Director, Medical Management: _____ Date: _____ Medical Director: _____ Date: _____	

PURPOSE: The purpose of this protocol is to state the Prior Authorization Criteria that the Medical Management Department will use as it pertains to Electrical Nerve Stimulator (ENS).

PROTOCOL:

- A. The prior-authorization specialist may approve **with prior authorization nurse review** and if **all** of the following are present:
 - 1. The patient has **reversible condition** associated with a risk of disuse of atrophy of a muscle or muscle group;
 - 2. Documentation indicates that the nerve supply to the affected muscle group is intact, including the brain, spinal cord and peripheral nerves **and**
 - 3. The ENS is not being used for facial nerve paralysis (i.e. Bell's Palsy).
- B. This criteria is a guideline for prior authorization and does not represent a standard of practice or care.
- C. This protocol addresses medical coverage issues only and does not review individual benefit coverage issues. In order to issue an authorization number, the procedure must meet medical guidelines and benefit coverage guidelines under the specific plan.
- D. If requirements are not met, Medical Director review is required.

MIHS Health Plans reserves the right to change the protocol for administrative or medical reasons without notification to external entities. This protocol is not intended to be utilized as a basis for a claim submission.